	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED
	PROVIDER OR SUPPLIER			STREET A	ODDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561	1	
(X4) ID PREFIX TAG F0000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	of Complaint INC Complaint INC Substantiated,	Federal/State re cited at F 242, 2. , 2011 er: 000517 per: 155714 100266770 rays, RN pe:	FOO	000	By submitting the enclosed may we are not admitting the truth of accuracy of any specific finding allegations. We reserve the riginor contest the findings or allegation part of any proceedings and subthese responses pursuant to our regulatory obligations. The fact requests the plan of correction considered our allegation of compliance effective June 9, 20 the state findings of the annual survey conducted on May 10th 2011.	or gs or ht to ons as omit cility be	
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6FCH11

Facility ID:

000517

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

			(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155714	A. BUILDING	00	05/10/2011
		100711	B. WING	ADDRESS, CITY, STATE, ZIP CODE	00/10/2011
NAME OF F	PROVIDER OR SUPPLIER			FOURTH ST	
	LAGE INC		OAKTO	DWN, IN47561	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	Total: 28	,			
	10141. 20				
	Sample: 5				
	These deficien	icies also reflect state			
		in accordance with			
			1		
	410 IAC 16.2.				
	Quality review	completed on May			
	12, 2011 by B	ev Faulkner, RN			
			1		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		ì '				X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155714	A. BUII		00	05/10/2	
		100714	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	03/10/2	
NAME OF F	PROVIDER OR SUPPLIER				FOURTH ST		
	LAGE INC		OAKTOWN, IN47561				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
F0242 SS=E	The resident has the schedules, and he or her interests, as care; interact with both inside and out choices about aspetacility that are sign. Based on obsetand record reversaled to ensure dressed and our reasonable time residents up art 5:00 A.M., for reviewed for me sample of 5. For D. Findings included the sample of 5. For D. Findings included the sample of 5. For D. The sample of 5. For D.	he right to choose activities, alth care consistent with his issessments, and plans of members of the community tside the facility; and make ects of his or her life in the nificant to the resident. rvation, interview, iew, the facility eresidents were at of bed at a e, and instead got ad/or dressed before 4 of 5 residents morning care, in a Residents A, B, C, and de: 4 4:55 A.M., CNA # 1 the shift staff "have a tells them when to	F0	242	F242 The corrective action taken for residents found to be affected by deficient practice is that Oak Vilnc. has written a new policy prohibiting the use of a "get up and that this list is no longer in Residents identified as A,B,C, a have been reassessed as to their preference of time to rise in the mornings. Residents A, B, and unable to communicate a time to prefer to rise in the morning at time of assessment. However, are able to communicate when are ready to get up on random of by opening eyes, attempting to etc. If no preference is stated of indicated no resident will rise by 5 a.m. Resident D is totally dependent with a diagnosis of Alzheimers and is unable to communicate wants or needs we exception of facial grimacing win pain. Therefore, this resident not be up in the mornings befor 6:00 am. Residents A, B, C, a careplans were updated to reflect these findings.	y the Illage, list" use. and D C are hey the they they lays rise, refore ith the hen will e nd D ct	06/09/2011
	provided a "Re	esident Shower ed May 3, 2011. The			The corrective action taken for other residents having the poter to be affected by the same defic practice is that all residents hav	itial ient	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155714	B. WIN	IG		05/10/2	011
NAME OF F	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	FOURTH ST		
OAK VILI	LAGE INC			OAKTO)WN, IN47561		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	schedule inclu	ded: "Night Shift			potential to be affected by this deficient practice. A house-wid	l _o	
	Get Ready Lis	t:Resident D, Get			assessment was completed to	ie	
	Up List:Resi	dent C, Resident A,			determine preference of rising t	imes	
	Resident B. And any others would				in the mornings. Based on the		
					outcome of the assessments res		
		reciated, especially			will rise at their preference whe	ther	
	when dayshift	is short staffed and			by statement or action. If no statement or action available no		
	especially on I	Mondays and			resident will rise before 5 a.m.	,	
	Thursdayspl	ease get more			Totally dependent residents wh	o are	
	residents ready				unable to communicate their wi		
	residents ready	y und/or up			will not rise until 6:00 a.m. A		
		- (0 /d d d 0			house-wide careplan audit will		
		ew, on 5/9/11 at 5:10			conducted with the careplans up according to the outcome of the		
	A .M., LPN # 1	l indicated night shift			assessments.	;	
	staff work from	n 10:00 P.M. until			400000111011		
	6:00 A.M.				The measures or systematic cha	inges	
	0.0011.1.1.				that have been put into place to		
	2 0 5/0/11	4 4 40 4 34			ensure that the deficient practic		
		t 4:40 A.M., upon			does not recur is that a mandato inservice was conducted for all	огу	
	entrance to the	e facility, Resident D			licensed or certified nursing sta	ff on	
	was observed	sitting in a reclining			the resident's right to make cho		
	Broda chair by	the nurses' station,			including the right to rise in the		
	_	dressed in street			mornings at their preference eit		
	~				statement or action. If no states or action available no resident v		
		esident's eyes were			rise before 5 a.m and totally	VIII	
	closed. LPN #	1 indicated at that			dependent residents who are un	able	
	time that there	was "a small group			to make needs known by statem	nent or	
	of residents the	at get their showers			action will not rise before 6:00	a.m.	
		d between 4:00 A.M.			The inservice included how to		
	_	" LPN # 1 indicated			determine if a resident, who is confused or unable to verbally		
					communicate, wishes to rise be	fore 5	
		O required total care			a.m. The requirement of follow	ing	
	from staff.				the plan of care was addressed	as	
					well.		
					<u> </u>		

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE :	
ANDILAN	OF CORRECTION	155714		LDING	00	05/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R		1	FOURTH ST		
OAK VIL	LAGE INC			OAKTO	WN, IN47561		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
mo		ecord of Resident D		mo	· · · · · · · · · · · · · · · · · · ·		DAIL
		on 5/9/11 at 8:10			The corrective action taken to		
	A.M. Diagnos			monitor the corrective action is Quality Assurance tool was	s a		
	not limited to.				developed and implemented to		
	Dementia.	, Trizmenner 5			monitor the rising time of all		
	Dementia.				residents. This tool includes the residents preference if available		
	An Initial Act	ivity Assessment,			Residents stating a preference	will be	
		indicated, "What			given that choice and will rise preferred time unless otherwise		
	· ·	· ·			indicated by the resident. Care		
	l	ke to get up in the			will be updated on an ongoing		
	morning? [Le	it blankj			This tool will be completed dai the Night Shift Charge Nurse a		
	T01	. N			reviewed by the Director of Nu		
		ent Minimum Data Set			or his designee weekly for four	-	
		ment, dated 5/4/11,			weeks, then monthly for three months and then quarterly for t	hraa	
		ident D was unable to			quarters. The outcome of this		
	_	nemory test, and was			will be reviewed at the monthly	y	
	1	npaired in cognitive			Quality Assurance meeting to determine if any additional		
	1	decision-making.			interventions are warranted.		
		essment indicated the			Completion Date June 9th, 201	.1	
	resident was t	otally dependent on					
	two+ persons	for transfer, dressing,					
	and personal l	nygiene.					
		on or a care plan was					
		ling the resident					
	wishing to get	t up before 5:00 A.M.					
	0 5/0/11 : 5	100 AM D 11 (D					
		7:00 A.M., Resident D					
		sitting in a Broda					
	chair by the n	urses station, eyes					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) M ¹ A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMP 05/10/2	LETED
	PROVIDER OR SUPPLIER		1, = 1,	STREET A	DDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	closed.						
		:30 A.M., Resident D sitting in the dining reyes closed.					
	C was observe wheelchair by groomed and f	the nurses' station,					
	The clinical record of Resident C was reviewed on 5/9/11 at 5:35 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia.						
	An Initial Activity Assessment, dated 5/9/08, indicated, "What time do you like to get up in the morning? 6 AM"						
	[MDS] assessi indicated the r problems, and assistance of t	nt Minimum Data Set ment, dated 5/3/11, esident had memory required extensive wo+ staff for transfer. essment indicated					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714		LDING	NSTRUCTION 00	(X3) DATE COMPI 05/10/2	LETED
	PROVIDER OR SUPPLIE	₹	•	200 W F	DDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
	Resident C re	•					
	dependence on 1 person for dressing, and extensive assistance						
	_						
	of two+ staff	for personal hygiene.					
	lacking regard	on or a care plan was ling the resident cup prior to 5:00					
	On 5/9/11 at 7:00 A.M., Resident C was observed sitting in her wheelchair by the nurses' station, eyes closed.						
		2:30 A.M., Resident C sitting in the dining r eyes closed.					
	was observed Resident A to	at 4:55 A.M., CNA # 1 ambulating with the nurses' station. as groomed and					
	was reviewed A.M. Diagnos	ecord of Resident A on 5/9/11 at 7:45 ses included, but were Advanced Dementia.					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 05/10/2	LETED
	PROVIDER OR SUPPLIER		<u> </u>	STREET A	ODDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561	I	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	dated 12/22/09 time do you li	vity Assessment, 9, indicated, "What ke to get up in the 9 or 8:00 AM"					
	assessment, da indicated Resi short-term and problem, requ assistance of o	dent A had a I long-term memory ired limited one person for extensive assistance of r dressing and					
	Documentation or a care plan was lacking regarding the resident wishing to get up prior to 5:00 A.M.						
	was observed	:00 A.M., Resident A sitting in a chair by ion, with her eyes					
	was observed	:30 A.M., Resident A sitting at the dining th her eyes closed.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MULTIPLE A. BUILDING B. WING	00	COM	TE SURVEY MPLETED D/2011
	PROVIDER OR SUPPLIEF	!	200 \	ET ADDRESS, CITY, STATE, Z W FOURTH ST TOWN, IN47561	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	B was observed dressed in a store over her. The clinical rewas reviewed A.M. Diagnos not limited to, An Initial Actidated 7/7/09, in	et 4:40 A.M., Resident ed to be lying in bed, reet shirt, with a sheet ecord of Resident B on 5/9/11 at 6:30 es included, but were Alzheimer's Disease. Evity Assessment, andicated, "What ke to get up in the				
	A Minimum D assessment, da Resident B ha and required e one person for and personal h Documentatio lacking regard wishes to get o morning prior	Data Set [MDS] ated 3/7/11, indicated d memory problems, extensive assistance of etransfer, dressing, hygiene. In or a care plan was ling the resident's dressed in the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	A. BUIL B. WING	DING	00 	COMPI 05/10/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
IAU	was observed wheelchair by groomed and of the following interest of the following interest of the night shift up "that early, expect to have	the nurses station, dressed. Twiew with the on 5/10/11 at 11:40 cated she had no idea was getting people and would not residents be up and to 5:00 A.M. unless it.		IAG			DATE	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION 00	(X3) DATE COMP: 05/10/2	LETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F0282 SS=D	facility must be proin accordance with plan of care. Based on obse and record rev failed to ensur interventions versidents dependent turned and every two houleast every 2 heresidents revie a sample of 5. C Findings inclu 1. On 5/9/11 arentrance to the was observed as	were followed, in that ndent for care were repositioned at least rs, and toileted at ours, for 2 of 4 wed for care plans, in Resident D, Resident	F0282	F282 The corrective action residents found to be deficient practice is treview was conducte and C specifically addependence for turn/and toileting. The caupdated accordingly, was given to each shicertified nursing staff for following the residents identified a The corrective action other residents having to be affected by the practice is that all respotential to be affected deficient practice. A of resident careplans specifically addressing dependence for turning and toileting of all residents.	a affected by the hat a careplan of for residents D ddressing their repositioning areplans were An inservice iff licensed and f as to the need ident's careplan and toileting of s D and C. I taken for the g the potential same deficient sidents have the ed by this housewide audit was conducted ing level of ing/repositioning	06/02/2011	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6FCH11

Facility ID:

000517

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	I DING	00	COMPLETED	
		155714	B. WIN			05/10/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			200 W I	FOURTH ST		
	LAGE INC				WN, IN47561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		ON
TAG		Aressed in street	-	TAG	Careplans were updated	DATE	
	groomed and dressed in street				accordingly. A list of residents	has	
	clothes. The resident's eyes were closed. LPN # 1 indicated at that				been placed in a binder at the n	ırse's	
					station with their specific		
	time that there	was "a small group			turn/reposition and toileting careplan. CNA assignment she	ets	
	of residents th	at get their showers			were also updated to reflect any		
	and get dresse	d between 4:00 A.M.			changes.		
	and 5:00 A.M.	" LPN # 1 indicated			The measures or systematic cha	nges	
	that Resident 1	O required total care			that have been put into place to		
	from staff.	•			ensure that the deficient practic	e	
	nom stan.				does not recur is that a mandat	· 1	
	D :1 .D	1 1.			inservice has been conducted for		
		s observed to remain			licensed and certified nursing so the requirement to follow a resi		
	in the reclining	g Broda chair at the			careplan at all times and specifi		
	nurses station	until 7:30 A.M.,			the turning/toileting and		
	when the resid	ent was moved to the			repositioning of a dependent resident. This inservice include		
	dining room w	here the resident			review of the issues of skin	u a	
	remained. At 8				breakdown.		
	resident was tr	ansferred to bed by			The corrective action taken to		
	CNA # 2 and #	\$\frac{1}{2}\$. The resident was			monitor the corrective action is	a	
	observed in th	e chair from 4:40			Quality Assurance tool was		
		5 A.M. without a			developed and implemented to	4	
		ge or incontinence			monitor the turning/toileting an repositioning of dependent residuals.		
	^	se of incommence			This tool will be completed by		
	check.				Charge Nurse on duty each shift		
		1 20 11 -			daily and reviewed by the Direct		
		cord of Resident D			Nursing weekly for four weeks, monthly for three months, quar		
	was reviewed	on 5/9/11 at 8:10			for three quarters. This tool wi	•	
	A.M. Diagnos	es included, but were			be used for random checks one	time	
	not limited to,	Alzheimer's			weekly by Director of Nursing.		
	Dementia.				outcome of this tool will be rev at the monthly QA to see if furt		
					action is warranted.	101	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155714		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :		
		A. BUILDING 00			05/10/2011		
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	FOURTH ST		
OAK VIL	LAGE INC			OAKTO	WN, IN47561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	THE APPROPRIATE	
		nt Minimum Data Set		1110	Completion Date 6-9-11		DATE
		ment, dated 5/4/11,					
		dent D was unable to					
	respond to a m	nemory test, and was					
	moderately im	paired in cognitive					
	skills for daily	decision-making.					
	The MDS asse	essment indicated the					
	resident was to	otally dependent on					
	two+ persons	for transfer, dressing,					
	and personal h	ygiene.					
	A Resident Ca	re Plan, initial date					
	3/6/08 and upo	dated on 2/11,					
	indicated a pro	oblem of "At risk for					
	skin breakdow	n R/T [related to]					
	[decreased] me	obility et [and] incont					
	[incontinent] c	of [bowels and					
	bladder]." The	approaches					
	included: "1. C	Change positions freq					
	when up in rec	eliner3. Check freq					
	keep clean et d	lry"					
		11:40 A.M., the					
		indicated she would					
	have expected her staff to						
	_	toilet the resident at					
	least every 2 h	ours.					
	2. On 5/9/11 a	t 4:40 A.M., Resident					

NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC OAK VILLAGE OAK VILLAGE INC OAK VILLAGE OAK VILLAGE OAK VILLAGE OAK VILLAGE OAK VILL	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC OAK VILLAGE OAK VILLAGE INC OAK VILLAGE OAK VILLAG	155714		A. BUILDING 05/10/2011					
OAK VILLAGE INC OAK OWN, INA 7561 OAK OW				B. WING		DDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES TO PROCEED BY TAKE OF COMMETTION TAG PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG PROCEED BY THE PERCEDED BY THE PERCEDED BY FULL TAG PROCEED BY THE PERCEDED BY THE PERCEDED BY THE PERCEDED BY THE PROCEED BY THE PERCEDED	NAME OF I	PROVIDER OR SUPPLIER						
REFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C was observed sitting in a wheelchair by the nurses station, groomed and fully dressed. Resident C's eyes were open. Resident C was observed to remain in the wheelchair by the nurses' station until 7:30 A.M., when the resident was then moved to the dining room where the resident remained. At 8:40 A.M., the resident was observed in the chair from 4:40 A.M. until 8:40 A.M. without a position change or incontinence check. The clinical record of Resident C was reviewed on 5:9/11 at 5:35 A.M. Diagnoses included, but were not limited to, Alzheimer's Dementia. A Resident Care Plan, initially dated 10:/10 and updated 2:/11, indicated a problem of "Increase incont. of bowels et bladder." The	OAK VIL				OAKTO'	WN, IN47561		
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indicated a problem of "Increase incont. of bowels et bladder." The		A Resident Ca	re Plan, initially					
incont. of bowels et bladder." The		dated 10/10 an	nd updated 2/11,					
		indicated a pro	oblem of "Increase					
approaches indicated, "Toilet q		incont. of bow	els et bladder." The					
,		approaches inc	dicated, "Toilet q					

∥ 15571 ⊿		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
		A. BUILDING 00			COMPLETED 05/10/2011		
<u> </u>			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		_
NAME OF F	PROVIDER OR SUPPLIER				FOURTH ST		
OAK VILI	LAGE INC			OAKTO	WN, IN47561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
1710		urs] et PRN [as		1110			DATE
	needed]"	arsjet i i i i i i i i i i i i i i i i i i i					
	neededj						
	The most rece	nt Minimum Data Set					
		ment, dated 5/3/11,					
		esident had memory					
		required extensive					
	*	wo+ staff for transfer.					
		essment indicated					
	Resident C rec						
	dependence or	_					
	dressing and to	-					
	_	stance of two+ staff					
		ygiene. The MDS					
		dicated Resident C					
		continent of bladder,					
	·	incontinent of					
	bowels.						
	On 5/10/11 at	11:40 A.M., during					
		the Administrator,					
		she would have					
		taff to toilet the					
	_	st every 2 hours.					
	This federal tag relates to						
	Complaint IN(~					
	3.1-35(g)(2)						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/10/2011		
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC			20	00 W F	DDRESS, CITY, STATE, ZIP CODE DURTH ST VN, IN47561		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	II PRE TA	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F0312 SS=D	of daily living rece to maintain good resonal and oral Based on obse and record reversiled to ensur for care were to repositioned at hours, and toil hours, for 2 of for care plans, Resident D, Resid	rvation, interview, iew, the facility e residents dependent turned and t least every two eted at least every 2 4 residents reviewed in a sample of 5. esident C	F0312	2	F312 The corrective action taken for residents found to be affected by deficient practice is that resident identified as C and D careplans reviewed. An inservice was conducted on all licensed and certified nursing staff to specific address that residents C and D be given care according to their careplan. Specifically they are turned/repositioned and toileted every two hours and prn regard of what time they rise in the mornings. Residents C and D a receive necessary services to maintain good nutrition, groom and personal and oral hygiene. The corrective action taken for other residents having the potent to be affected by the same deficient practice is that all residents having the potent.	y the ts were cally are to to be less re to ing, the attial ient	06/09/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 6FCH11

Facility ID:

000517

If continuation sheet

Page 16 of 22

X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155714 05/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 W FOURTH ST OAK VILLAGE INC OAKTOWN, IN47561 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE potential to be affected by the clothes. The resident's eyes were deficient practice. A house-wide closed. LPN # 1 indicated at that review of all residents careplans has time that there was "a small group been conducted. Based on the outcome of the review it was of residents that get their showers determined which residents are and get dressed between 4:00 A.M. unable to carry out activities of daily living. All residents who are unable and 5:00 A.M." LPN # 1 indicated to carry out activities of daily living that Resident D required total care will receive the necessary services to from staff. maintain good nutrition, grooming and personal and oral hygiene in accordance to their individual The clinical record of Resident D careplan. was reviewed on 5/9/11 at 8:10 The measures or systematic changes A.M. Diagnoses included, but were that have been put into place to not limited to, Alzheimer's ensure that the deficient practice does not recur is that a mandatory Dementia. inservice was conducted for all licensed and certified nursing staff on The most recent Minimum Data Set the policy of providing necessary services to maintain good nutrition, [MDS] assessment, dated 5/4/11, grooming, and personal and oral indicated Resident D was unable to hygiene for any resident who is unable to carry out activities of daily respond to a memory test, and was living. Completion of careplans, moderately impaired in cognitive updating of careplans, and following skills for daily decision-making. the resident's plan of care were also addressed The MDS assessment indicated the resident was totally dependent on The corrective action taken to monitor to assure performance and two+ persons for transfer, dressing, compliance is that a Quality and personal hygiene. Assurance tool was developed and implemented to monitor the turning/repositioning and toileting of A Resident Care Plan, initial date dependent residents. This tool will 3/6/08 and updated on 2/11, be completed by Charge Nurse each shift. The Director of Nursing will indicated a problem of "At risk for

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
		155714	B. WING 05/10/2011				
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	NAME OF PROVIDER OR SUPPLIER			200 W F	FOURTH ST		
	LAGE INC				WN, IN47561		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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IAG				IAU	monitor this tool daily and perfe		
		n R/T [related to]			random checks throughout each	• • • • • • • • • • • • • • • • • • •	
	[decreased] m	obility et [and] incont			weekly for four weeks, monthly	• • • • • • • • • • • • • • • • • • •	
	[incontinent] of	of [bowels and			three months and quarterly for	• • • • • • • • • • • • • • • • • • •	
	bladder]." The	approaches			three quarters. The outcome wi	• • • • • • • • • • • • • • • • • • •	
	included: "1. C	Change positions freq			reviewed at the monthy Quality Assurance meeting to determine	• • • • • • • • • • • • • • • • • • •	
		cliner3. Check freq			any additional interventions are		
	1 ^	•			warranted.		
	keep clean et o	лу			completion date 6-10-11		
	On 5/9/11, Res	cident D was					
	1						
		ng in a reclining					
		the nurses station at					
	4:40 A.M., 5:2	25 A.M., and 7:00					
	A.M. Resident	t D was observed					
	sitting in a Bro	oda chair at the dining					
	room table at	7:30 A.M. and 8:00					
		A.M., CNA # 2 and					
	CNA#3 were						
		ey lay Resident D					
		eakfast, and both					
	responded that	t they did. A skin					
	assessment wa	is requested on					
	Resident C wh	nen they were able to					
	lay her down.						
	On 5/9/11 at 8:55 A.M., CNA # 3 indicated they were going to						
	1	ent D to bed. CNA#					
		3 transferred the					
	resident to bed	l with a mechanical					
	l						

05/10/2011					
B. WING O3/10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561					
TION (X5) LD BE COMPLETION ROPRIATE DATE					
DATE					
TIC					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		(X2) MUI A. BUILE B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/10/2	LETED	
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC				STREET A	DDRESS, CITY, STATE, ZIP CODE FOURTH ST WN, IN47561		
(X4) ID PREFIX TAG	summary statement of deficiencies (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) needed]"		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROL DEFICIENCY)	BE	(X5) COMPLETION DATE
	REGULATORY OR LSC IDENTIFYING INFORMATION)						

000517

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155714		(X2) MUL A. BUILD B. WING		NSTRUCTION 00	(X3) DATE: COMPL 05/10/2	ETED		
NAME OF PROVIDER OR SUPPLIER OAK VILLAGE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 200 W FOURTH ST OAKTOWN, IN47561					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR On 5/9/11 at 8	CTATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) :40 A.M., CNA # 2		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	and CNA # 3 in going to take I bathroom. CN Resident C was but that she "s when she has brief was obseturine, and the into the commash-like area the resident's I On 5/10/11 at interview with she indicated sexpected her si	Resident C to the A # 3 indicated as usually incontinent, ometimes tells us to go." The resident's erved to be wet with resident also voided ande. A raised, was observed over buttocks. 11:40 A.M., during a the Administrator, she would have staff to toilet the st every 2 hours.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155714	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMP 05/10/2	LETED
NAME OF F	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP C	CODE	
OAK VIL	LAGE INC			DWN, IN47561		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE